BRAMPTON EAST MEDICAL GROUP
CENTRAL BRAMPTON FAMILY HEALTH TEAM

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(905) 451-1937
*DENOTES PROFESSIONAL CORPORATION

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

This form is to be used for the purpose of authorizing someone other than yourself, to communicate with our staff, with regard to your medical information. ***(See reverse side for instructions.)***

1. **Primary Patient, *COMPLETE IN FULL 16 years of age and older.***

Name - Last, First, MI		
Street Address		Telephone # (xxx) xxx-xxxx
City	Province	Postal Code
Date of Birth mm/dd/yyyy		

2. The person listed below is authorized to access my medical information.

Name - Last, First, MI		
Street Address		Telephone # (xxx) xxx-xxxx
City	Province	Postal Code
Date of Birth mm/dd/yyyy		

Relationship: □ Spouse/Partner □ Guardian □ Power of Attorney □ Other _____

□ Father □ Mother □ Son □ Daughter

3. INFORMATION TO BE RELEASED:

Only for the following subject: _____

All subjects except for the following: _____

(authorized individual(s) must provide personal identification at time of pick up for verification)

A separate request (completed documentation release form) will be required for a copy of medical documentation.

**I understand that this is an uninsured service not covered by my medical insurance plan. I realize that there may be a charge for this service and that I am responsible for the cost.*

4. This authorization will remain in effect until revoked by you. If you wish to limit the duration of this authorization, please specify the end date below:

End Date: _____

5. I authorize release of my medical information in accordance with the specification listed above. (A photocopy of this consent shall be valid as the original).

I acknowledge that I have read this document in its entirety and that I fully understand my consent to release my PHI.

I have asked any questions that may have occurred to me and have been answered to my satisfaction.

Authorization: In accordance with PHIPA, authorization must be signed by the patient.

6. Signature of Patient: _____ Date: _____

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Privacy regulations require your health care team not divulge any information to unauthorized persons. In today's world, it is common for a spouse or partner to arrange appointments for their family members, to check if they should come back for a follow-up, etc. It is permissible for a parent or legal guardian to manage these tasks for a minor. But not permissible for a spouse to act on your behalf unless authorized. We required written consent to be on file.

Children that are 16 years of age or older must also grant authorization to a parent or guardian.

By default, a parent or guardian is assumed to have authorization for a minor. It becomes difficult to manage this if the surnames of any of the parents are different than the minors, reside at a different residence or there is rules regarding custody. In these cases please supply full details in writing.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that have already been made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

Central Brampton Family Health Team/Brampton East Medical Group, 60 Gillingham Dr. Suite 200, Brampton, ON L6X 0Z9

Signatures. Generally, if you are 16 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. A spouse can not authorize disclosure of medical information for you unless they have legal rights to do so.